The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-258-3334 or visit www.bluecrossnc.com/booklets and sign into the Member Portal. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call at 1-877-258-3334 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,000 Individual/$1,000 Family Member/$2,000 Family. Out-of-Network: $2,000 Individual/$2,000 Family Member/$4,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and most services that may require a copayment.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,000 Individual/$5,000 Family Member/$10,000 Family. Out-of-Network: $10,000 Individual/$10,000 Family Member/$20,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bluecrossnc.com/FindADoctor or call 1-877-258-3334 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness.	$25 copayment	30% coinsurance	Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits.
	Specialist visit	$50 copayment	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	-You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. -Limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossnc.com/rxinfo	Tier 1 Drugs	$10 copayment	$10 copayment	-Prior authorization may be required and coverage limits may apply. *See Prescription Drugs section. -Copayment applies to a 30-day supply. -For infertility Dosage Limits lifetime maximum applies.
	Tier 2 Drugs	$35 copayment	$35 copayment	
	Tier 3 Drugs	$60 copayment	$60 copayment	
	Tier 4 Drugs	25% coinsurance	25% coinsurance	
	Tier 5 Drugs	25% coinsurance	25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com/booklets

PROD - P385911 7606341 PIL-M0007G2 R0004UR B1-LAN00308 LNR00059

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copayment/No IP Admission; 20% coinsurance/With IP Admission	$300 copayment/No IP Admission; 20% coinsurance/With IP Admission	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copayment	$100 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/office; 20% coinsurance/outpatient	30% coinsurance	-Prior authorization may be required or services will not be covered.
	Inpatient services	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered.
If you are pregnant	Office visits	No Charge	30% coinsurance	-Exceptions may apply. *See Family Planning section.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
	Rehabilitation services	$50 copayment/office; 20% coinsurance/outpatient	30% coinsurance	-Combined 30 visits for physical/occupational therapy and chiropractic services. 30 visits for speech therapy. Visit limits do not apply to mental illness diagnoses.

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com/booklets

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$50 copayment/office; 20% coinsurance/outpatient	30% coinsurance	Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	20% coinsurance	30% coinsurance	-Coverage is limited to 60 days. -Prior authorization may be required or services will not be covered
	Durable medical equipment	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered -Limits may apply.
	Hospice services	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service.
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com/booklets

PROD - P385911 7606341 PIL-M0007G2 R0004UR B1-LAN00308 LNR00059

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care other than palliative or cosmetic

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or contact Blue Cross NC at 1-877-258-3334 or www.BlueConnectNC.com. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross NC at 1-877-258-3334 or www.BlueConnectNC.com. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, if applicable. You may also contact N.C. Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or Toll free (855) 408-1212. Additionally, a consumer assistance program can help you file your appeal. Contact Health Insurance Smart NC, N.C. Department of Insurance, at 1201 Mail Service Center, Raleigh, NC 27699-1201, 855-408-1212 (toll free).

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-258-3334.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-258-3334.

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com/booklets

PROD - P385911 7606341 PIL-M0007G2 R0004UR B1-LAN00308 LNR00059

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-258-3334.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-258-3334.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Specialist office visits *(prenatal care)*	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests *(ultrasounds and blood work)*	
Specialist visit *(anesthesia)*	
Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$60
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,120**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests *(blood work)*	
Prescription drugs	
Durable medical equipment *(glucose meter)*	
Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1,000**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Emergency room care *(including medical supplies)*	
Diagnostic test *(x-ray)*	
Durable medical equipment *(crutches)*	
Rehabilitation services *(physical therapy)*	
Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

PROD - P385911 7606341 PIL-M0007G2 R0004UR B1-LAN00308 LNR00059

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English
ATTENTION: If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-206-4697 (TTY: 711) or speak to your provider.

Spanish / Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-206-4697 (TTY: 711) o hable con su proveedor.

Chinese / 中文
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-206-4697（文本电话：711）或咨询您的服务提供商。

Vietnamese / Việt
LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cấp miễn phí. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-206-4697 (Người khuyết tật: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Korean / 한국어
알림: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-206-4697 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

French / Français
ATTENTION: Si vous parlez français, vous pouvez bénéficier de services d'assistance gratuits. Vous avez également à votre disposition des outils et services supplémentaires vous permettant de fournir des informations dans un format accessible, sans frais. Appelez le 1-888-206-4697 (TTY : 711) ou parlez à votre fournisseur.

Arabic / العربية
تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر مساعدة وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. يُرجى الاتصال على الرقم 1-888-206-4697 (TTY: 711) أو تحدث مع مزود الخدمة الخاص بك.

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Hmong / Lus Hmoob
LUG CEEV TSHWJ XEEB: yog has tas koj has lug Hmoob muaj cov kev paab cuam txhais lug pub dlawb rua koj. Cov kev paab hab cov kev paab cuam ntxiv kws tsim nyog txhawm rua muab lug qha paub ua cov hom ntaub ntawv kws tuaj yeem nkaag cuag tau rua los kuj yeej tseem muaj paab dlawb tsis xaam tug nqe dlaab tsi tuab yaam nkaus. Hu rua 1-888-206-4697 (TTY: 711) los yog thaam nrug koj tug kws muab kev saib xyuas khu mob.

Russian / РУССКИЙ
ВНИМАНИЕ: Если Вы говорите на русском, то Вам доступны бесплатные услуги языковой поддержки. Соответствующие инструменты и информационные сервисы также предоставляются бесплатно. Позвоните по телефону 1-888-206-4697 (TTY: 711) или обратитесь к своему поставщику услуг.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-206-4697 (TTY: 711) o makipag-usap sa iyong provider.

Gujarati / ગુજરાતી
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો, મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-888-206-4697 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Mon-Khmer, Cambodian / ភាសាខ្មែរ
កំណត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាតតគិតថ្លៃគឺមានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មសមរម្យក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បានក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទភលេខ 1-888-206-4697 (TTY:711) ឬនិយាយជាមួយផ្តល់សេវារបស់អ្នក។

German / Deutsch
WICHTIGER HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-206-4697 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi/ हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-888-206-4697 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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Laotian / ລາວ
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-888-206-4697 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Japanese / 日本語
お知らせ：日本語をお話しの場合、無料の言語支援サービスをご利用いただけます。アクセス可能な形式で情報を提供するための適切な補助的なサポートやサービスも無料でご利用いただけます。1-888-206-4697 (TTY: 711) にお電話いただくか、プロバイダーにお問い合わせください。

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